ORIGINAL ARTICLES

Scientific and General

MEDICAL PRACTICE OF THE FUTURE: AS A MEDICAL ADMINISTRATOR VIEWS IT*

ANTHONY J. J. ROURKE, M. D.
San Francisco

PROBABLY there are a great many of you who do not have the time nor the inclination to concern yourselves with medical economics. With the increased load placed upon private practitioners of medicine because of the War, I am sure that most of you find little time for reading beyond that of a purely clinical nature. However, the problem of medical economics and the method of distributing medical care is, without a doubt, the most important problem facing the medical profession. Before further discussion of this subject, I should like to state that my views are those of a medical administrator and not a practicing physician.

I should like to discuss, first, health plans as operated and directed by industry. You are aware, I am sure, that there have been many and that they have been in existence for a great number of years. As examples, we have plans operated by Endicott-Johnson, Sears-Roebuck, Western Electric, National Cash Register, General Motors and, here in California, the Permanente Foundation.

PREPAID HEALTH INSURANCE

In considering prepaid health insurance of any kind, the following facts should be borne in mind: In the States of Washington and Oregon as early as 1930, county medical societies offered service on a prepayment basis. The California Physicians' Service was established in this State in 1939 as the first state-wide medical plan under the sponsorship and control of the medical profession. Since that time the States of Massachusetts, New Jersey, Pennsylvania, Delaware, North Carolina, Michigan, and Colorado have formed state-wide plans. At the present time, medical plans are operated by local medical societies in New York, Texas, and Washington. As of March 1, 1943, there were 800,000 subscribers to medical plans in the twelve states operating such plans. In the State of Michigan alone, over 440,000 citizens have medical coverage. This evidence should adequately refute the statement that physicians were kicked out of medical societies, in most instances, because they had participated in prepayment medical care. In addition to the medical service coverage, there were over 12,500,000 people having Blue Cross hospital coverage and over 5,000,000 having hospital coverage from commercial insurance companies.

As you all know, health programs, operated by industry in the main, envision a prepayment program with physicians on a salary, practicing as a group with a hospital as the center, under the management of industry. The following quotation from Mr. Kaiser, taken from Dr. de Kruif's book, "Kaiser Wakes the Doctor," indicates his program: "Will the manufacturers now dare to organize, finance and manage medical centers in every industrial community, where medical service could be purchased on an insurance basis at a cost which would bring not only the skill and facilities, but all the advantages of research within the reach of the common man?"

Indicating his idea for one source of supply of doctors for a salaried program, de Kruif, in his book, gives credence to an opinion I do not share when he says: "Immediately postwar, there'd be scores of thousands of young physicians coming back to civil life who'd had a taste of group medical care, of giving the most scientific medical care to millions, with no consideration of the cost of it—and on salaries which made their own lives secure." My personal experience indicates to me that the greater portion of the physicians in the military service are there to do their patriotic duty under a régime of military discipline, and are willing to be regimented for the duration. The great need which allows them to accept this regimentation in no way means their acceptance of it for a lifetime.

ATTITUDE OF THE MEDICAL PROFESSION

Physicians, in general, do not object to spreading the cost of medical care of the few among the many. Nor do they believe in monopolistic control of the healing power; but they do feel that, because of the complicated nature of medical practice, it should remain in the hands of the physicians, and that such physicians should become trustees or guardians for the public of this great human necessity which ranks with the other two great needs of food and shelter.

Much of the printed material and many of the radio broadcasts today fail to point out that medicine in America is at one of the highest levels of any place in the world and that it is the earnest desire of physicians to maintain that level—and continue to raise it—for the benefit of the public and not for their own personal gains, as has been so many times indicated.

One author has indicated that, as soon as a health plan had started and got under way, people stopped dying. The reader is left with the inference that, because of the plan, the death rate had been greatly reduced. In all fairness to medicine as it has developed in America today, it should be pointed out that the death rate from pulmonary tuberculosis in 1912 was 125 per 100,000 estimated population, in 1920 it dropped to 97, and in 1938 it had dropped to 44.6. In twenty-six years the rate had dropped to about one-third of the original. It should also be noted that the infant mortality rate in 1916 was 101 per 1,000 live births, in 1930 it had dropped to 64.6, and in 1940 it had dropped to 47. The foregoing sets of figures, which may be demonstrated in other diseases, indicate that progress has been made in medicine and that it may be expected to continue.

* One of the addresses in a symposium given at the 75th Anniversary San Francisco County Medical Society November 7, 1943.

It is very unfortunate that the people who have read the 15,000 printed copies of de Kruif's book could not have the same knowledge and background that the men and women of the medical world have. Handling facts very loosely, de Kruif refers to the 40 per cent of our boys who have been rejected from the draft, a large part of them physical wrecks, because they never did have decent medical care. He fails, however, to point out that a large percentage of these young men have been physically disqualified because of poor vision and flat feet, which are in no way going to be affected by prepaid medical service or early medical care.

DE KRUIF-KAISER PROPOSITIONS

De Kruif brings his book* to a conclusion with the following description of Mr. Kaiser's vision: "The medical mercy of these workshops can now rapidly wipe out the curse of syphilis. It can cut the present death toll from cancer by more than one-third. It can begin to conquer the rheumatic heartwreck that saps the strength of hundreds of thousands of our young people, the heartbreak that yearly kills them to the number of 40,000. It can abolish the misery and the insanity of women's change of life. By the skilled use of the new powerful hormones, it can extend the sexual activity and lengthen the vigorous prime of life of men, so that we will no longer say that we grow old too quick and wise too late. It will abolish the prostate gland misery that makes so many old men social outcasts. It will wipe out tuberculosis with a speed that will frighten the executives of the National Tuberculosis Association. This new group medical mercy will sound the death knell of still murderous lobar pneumonia and will remove the strength-sapping infection of gonorrhea from men and its maiming curse from women. In the new health centers our physicians and chemists will uncover and correct the widespread chemical hidden hunger, the vitamin starvation that gnaws the nation's nerves and weakens its muscles. Here, too, the new shock therapy will be turned against early mental sickness—to rob our asylums of hundreds of thousands of their tragic victims. Practicing physicians will co-work with eye specialists to check the blindness of glaucoma in its beginning. With all science instantly available, the doctors of these new hospitals will cut the death and maiming of newborn babies to a low that will excite the envy of Dr. Herman N. Bundesen—greatest of all fighters for the lives of children. And this community group prepaid medicine, freeing doctors from economic pressure, will cut down the pitiful toll of maiming, and of death, that exists because of surgery that is remunerative first and curative afterward." I wonder if Mr. Kaiser's vision includes the attracting of the right type of person to the medical profession; the assurance of a good medical education, the establishment of good hospital residencies; the stimulation of active, never-ending research; or whether it will develop more scientifically trained, emotionally endowed authors.

Kaiser, in his program, points to great profits which are bound to accrue in the operation of medical centers and he proposes that such profits be redirected into the enlargement and improvement of medical facilities throughout the country. Why should such altruism apply to profits derived from health care when history reveals to us that profits derived from industry did not establish protective guards for dangerous machinery, clean and comfortable rest rooms, lunch-room facilities, reasonable working hours, sick-leave benefits, vacation periods, retirement plans, and compensation for industrial accidents, until such time as legislative action occurred? What assurance do we have that the operation of health centers by industry with the employment of salaried doctors will not open up another field for corporate profits? In summarizing my remarks on the Kaiser type of medicine, I should like to point out to you that his plan is not new. That his idea of spreading the cost is not new. That his program is experimental and much too young to warrant a 158-page biography. That his health program at the time of de Kruif's book did not include the women and children in his Richmond yards. That, in comparison with other medical centers and hospitals, his program is far from complete, since he does not operate a nurses' training school, a school for dietitians, a residency and fellowship program, laboratories for experimentation, the training of physical therapists, nor does his program give a history, because of its youth, of any developments toward the improvement of medical care. Many of the problems, paramount among which is the matter of crowding, may be seen daily at the Permanente Foundation Hospital in Oakland. Three beds frequently occupy the space allotted to two. This is not unusual and not unjustified in our present situation.

I have no quarrel with Mr. Kaiser regarding the medical plan which applies to his shipyards; nor with his medical staff who are products of the same type of medical schools from which both you and I have graduated. However, I do have, and believe you also will have, a violent objection to Paul de Kruif's description of the Permanente Foundation which, by inference, leaves the reader with a vivid picture of every private practitioner as a medical Shylock prescribing x-rays only for the annointed, vitamins only for the shipbuilding industrialists, and with hospitals reluctantly admitting the ill and throwing them out on the sidewalk long before they are well.

WHAT THE PUBLIC SHOULD KNOW

I wish that it were possible for the medical profession to get across to the public:

1. That nearly all physicians throughout the country agree, and always have, with Mr. Kaiser's desire to bring to our citizens the best and most adequate diagnostic facilities and early medical care.

2. That thousands of physicians throughout the country have taken part, and are taking part, in prepayment medical programs in an attempt to bring this care to the public.

* For review of de Kruif's book, see October issue of CALIFORNIA AND WESTERN MEDICINE, on pages 207 and 244.

3. That thousands of physicians throughout the country have no quarrel with Mr. Kaiser regarding his wartime program, but they do not share his ideas for postwar medicine under the management of industry.

4. That in a profession where it is desirable to approach, as nearly as possible, an exact science, publicity of an emotional nature is not desirable.

5. That medical conservatism in diagnostic and therapeutic measures, as well as methods of distribution, have saved the American public much suffering, many heartaches, and much money.

6. That a medical plan, a hospital scheme, beautiful institutions, and shining laboratories would be of no avail were it not for the well-trained, emotionally stable physician. The public should know now, more than ever before, that its medical care will only be of value if directed by the hands and minds of well-trained physicians.

7. That the American physician is not as selfish as he has been pictured, and the great majority of the medical profession, even though they have a personal interest in their activities, are anxious that the profession be guarded and carried on for the benefit of the public, at its present high level.

8. That the prepayment health service, of the type operated by industry, does not allow the free choice of physician and the free choice of hospital. This particular point has always been felt to be of utmost importance in any health care program.

9. That, while American medicine costs well over $2,000,000,000 per year, the American public also spends for the luxury items of tobacco, cosmetics, and liquors a sum which amounts to about $5,000,000,000 per year.

GOVERNMENTAL APPROACHES ON HEALTH CARE: WAGNER S. 1161

Now, let us turn from the industrial approach to the private practice of medicine; to the governmental attempt to encompass this field. This governmental approach crystallized itself in Senate Bill 1161, which was introduced to the Seventy-eight Congress in its first session by Mr. Wagner of New York. This bill, frequently referred to as the Wagner-Murray-Dingell bill, proposes an amendment to the existing Social Security Act and includes, among other things, to establish a federal system of medical and hospital benefits; to encourage and aid the advancement of knowledge and skill in the provision of health service and in the prevention of sickness, disability, and premature deaths. This new bill would impose a tax of 6 per cent on the wages of all individuals earning up to $3,000 per year and a similar tax of 6 per cent upon the employer. A self-employed individual may obtain the benefits under this proposal, if it becomes law, upon the payment of a tax of 7 per cent on the market value of his services up to $3,000 per year. Hospitalization benefits under this program shall be a maximum number of thirty days, placing the authority with the Surgeon-General to extend this coverage to ninety days for the following calendar year, provided the funds are adequate.

The operation of this program, in its clinical aspects, is placed in the hands of the Surgeon-General of the Public Health Service, empowering him to enter into contractual arrangements with physicians and hospitals. All financial arrangements are left under the control of the Social Security Board, who will authorize all expenditures from the trust fund established by the above taxation. The Surgeon-General will have an advisory medical and hospital council to consist of the Surgeon-General, as chairman, and sixteen members to be appointed by him. It should be carefully noted that this council is to be advisory only and without power, thereby depending entirely upon the integrity of each surgeon general to accept and value the Council's advice. Such members shall be selected from panels of names submitted by the professional and other agencies and organizations concerned with medical service and education and with the operation of hospitals, and from among other persons, agencies or organizations informed on the need for or provision of medical, hospital or related services and benefits. The Surgeon-General will also establish fee schedules, qualifications for specialists, determine the number of individuals for whom any physician may provide service and determine what hospitals or clinics may provide service for patients. In all the above matters, the Surgeon-General may be advised by the Advisory Council. Payments to physicians may be made on any of the following four bases: According to a fee schedule approved by the Surgeon-General; on a per capita basis—the amount varying according to the number of individuals on physicians' lists; on a salary basis—whole or part time—or a combination or modification of these bases as approved by the Surgeon-General.

Section 912 of the bill further provides that the Surgeon-General and Social Security Board jointly shall have the duty of studying and making recommendations as to the most effective methods of providing dental, nursing and other needed benefits not already provided under this title. This bill covers ninety pages and was introduced by Mr. Wagner on June 3, and referred to the Committee on Finance. For those of you who have time, I should strongly urge getting a copy of this bill and reading it. Without further detail regarding provisions of this bill, I should like to discuss it in general.

VIEWS OF CHAIRMAN OF UNITED STATES SOCIAL SECURITY BOARD

Many things may be, from time to time, read into this legislation if it is passed. Perhaps it might be well to review some of the attitudes of the Social Security Board as voiced by Mr. Altmeyer, its chairman. He envisages the hospital as the center of coördinated services for the well and for the sick—a community center for prevention as well as diagnosis and cure. Mr. Altmeyer states that the whole cost of hospital care as a potential community service falls upon the one family out of four or five who, in the course of a year, uses that service and that the cost of hospital care must be distributed

among groups of people and over periods of time. When approached with the statement that in one decade over 12,000,000 people have been covered with Blue Cross Hospital Service, he states: "Ten times as many are outside these voluntary prepayment plans. Indifference and lack of foresight are barriers which cannot be hurdled by voluntary selling." Unfortunately, the indifference and lack of foresight which Mr. Altmeyer described cannot be denied on the part of some of our physicians and some of our hospitals.

However, thousands of our physicians appreciate the need for spreading the cost of medical care for a segment of the population and their participation in prepayment plans, similar to the California Physicians' Service, is tangible evidence of this appreciation. The public should be made aware of this. Also, many physicians value close association with hospitals and feel the value of centering medical activities there. The public should be made aware of this, but these same physicians feel that this close association may be effected and still retain their identity as individuals with free right of action. The public should know this. Where hospitals are strategically located, facilities for doctors' offices should be encouraged. But in the meantime the public should know that many large downtown and uptown doctors' office buildings now house, nearly in complete form, diagnostic facilities in one building, with the close association of many doctors.

We continually hear repeated the fact that the Federal Government has no intention of disturbing private voluntary effort, even under the provisions of the Wagner bill. Mr. Altmeyer states, in referring to voluntary hospitals: "These institutions have been the mainstay of general hospital service. More so in this country than elsewhere. They have been and are a notable expression of community action and community service; a symbol of fellowship and compassion among our people. The social insurance proposals for hospital benefits offer no threat to the voluntary hospitals. There is nothing in the proposals which proposes or intends that the social insurance system shall interfere with hospital operations or invade the field of hospital administration properly reserved to the individual institutions." One is immediately reminded of the old adage that "He who pays the fiddler calls the tune." Can it be possible that this adage, which has stood the test of time, will no longer be true?

VETERANS' ADMINISTRATION PROGRAM: ITS RECORD

I believe that this is a particularly good time to consider the history of federal hospitalization and to review the Veterans' Administration Program which was created by an Act of Congress on October 6, 1917, authorizing the medical treatment of persons disabled in World War I. It was the first legislation of this type in our national history. Following the close of World War I, there were 251,916 disabled service men discharged from the service. Medical care to this group was furnished, in the beginning, by the U. S. Public Health Service in the twenty marine hospitals and the Tuberculosis Sanitarium at Fort Stanton, New Mexico. In addition to this, the Surgeon-General took over eight hospitals in Army cantonments and contracted for the utilization of several hundred civilian hospitals. By June of 1920, fifty-two federal hospitals were being used with a bed capacity of 11,639 and there were 26,850 available beds in civilian contract hospitals; a total reservoir of 38,489 beds. Brigadier General Frank T. Hines, Administrator of Veterans' Affairs, in a speech at Buffalo, New York, in September, 1943, stated that, because the type of service afforded in a number of civilian contract hospitals was not satisfactory, the Secretary of the Treasury, in his report, criticized the situation, with the result that on March 4, 1921, $18,600,000 was appropriated by Congress. That again, on April 20, 1922, $17,000,000—making a total of $35,600,000—was appropriated for the erection of permanent federal hospitals. By 1924 there were forty-four federal hospitals operating 26,000 beds.

In April, 1922, Congress authorized hospital treatment for diseases or injuries not war connected for veterans of the Spanish-American War, the Philippine Insurrection, and the Boxer Rebellion. On June 7, 1924, Congress passed an act which assumed that all tuberculosis and psychiatric conditions occurring before January 1, 1925—six years after the Armistice—to be military connected. At this time there were a number of empty beds in the forty-four federal hospitals, and Congress, therefore, authorized the acceptance of all veterans for hospital care to the limit of empty beds, whether the condition was service connected or not. On March 20, 1933, the benefits for non-service connected injuries were repealed, but in the following year, on March 29, 1934, all such benefits were reinstated.

By June 30, 1937, the Veterans' Administration was operating 81 hospitals in 43 states with 47,420 beds, plus 2,159 beds in other federal hospitals. From 1919 until 1936, $149,222,000 have been appropriated by Congress for new hospitals, domiciliary and out-patient facilities and, in addition, $23,478,000 had been expended from regular fiscal funds for permanent improvements and extensions. On May 8, 1940, the President approved a ten-year program to enlarge bed capacities to 100,000. In the early part of 1942, because of the declaration of war, this was accelerated so that, at the present time, there are now being operated by the Veterans' Administration, ninety-three hospitals with 61,770 beds.

I am sure you are all familiar with the system of practicing medicine under the program of the Veterans' Administration, and I would bring to your attention the fact that with a potential ten million persons connected with the military service, the medical program for the veterans of World War II will make the program I have just described appear miniature. This is particularly true when one reads the following excerpt from General Hines' speech: "Whereas, in World War I less than 35,000 women served as army or navy nurses,

yeomanettes, and marinettes, and thereby earned such entitlement, the Veterans' Administration will now be concerned with several hundred thousand women, who will be potentially eligible for hospital treatment not only for diseases or injuries resulting from service in the armed forces, but for any intercurrent conditions (other than pregnancy or parturition) that may develop during their lives." I am sure that you agree with me that we want the very best medical program available for the veterans of this war, but I am also sure you will agree that neither the veterans nor the physicians are entirely in accord as to the best method of furnishing such medical care. Any discussion or planning of postwar medical care which does not take into consideration the medical care of the veterans of World War II will be unrealistic.

UNITED STATES PUBLIC HEALTH SERVICE AND HEALTH PLANS

I should personally be very much happier, if we must have federalized medicine, to which thesis I do not concur, if such a program in its entirety were formulated, administered and governed by the trained physicians of the United States Public Health Service. It is quite evident to me, from the public utterances of the chairman of the Social Security Board and the Surgeon-General of the Public Health Service, that a background of medical education plays a great part in medical planning. The following are a few statements made by Doctor Parran in his recent talk: "Lack of capacity to buy our service should not deprive anyone of the best. The total cost is well within the individual and collective ability of the population to pay." Such a statement certainly allows for private enterprise to do the job on a prepaid basis. Doctor Parran further states: "Among the poorer classes of our population, infant mortality is highest, expectancy of life is lowest, the amount of sickness is greatest and, in particular, the rates of such preventable diseases as tuberculosis and syphilis are most prevalent. In this country, death rates for these groups have been progressively downward, but there is a shocking disparity between geographic as well as economic groups." I believe that Doctor Parran, in such statements, indicates much more factually than does the chairman of the Social Security Board or certain popular authors, that private medicine has done a job in many areas. I am sure that we will agree with the Surgeon-General that in poverty-stricken areas, medical service is not adequate, and I hope, too, that he will agree with us that a plan for the entire country need not be patterned to meet the needs of the poverty-stricken areas. Doctor Parran, later in his talk, lays down the challenge to American medicine in the postwar world with the following statements: "Recent developments make it possible within a few years after the War and at moderate costs, to locate every case of tuberculosis in the population. The malaria-control authorities tell me that if we were to develop our present controlling forces, we can anticipate the substantial eradication of malaria in this country within another decade. One-third of our cancer deaths are preventable if we were to provide for all people in all parts of the country the modern facilities for diagnosis and treatment now available to a few." Doctor Parran leaves the way open for private medicine to do the major portion of the necessary health program which seems to be a different attitude than that taken by the chairman of the Social Security Board, who indicates that compulsory health insurance is the only way to meet our needs. To quote Doctor Parran: "I believe there will be a growing sentiment for extending the prepayment principle through compulsory insurance or otherwise, to include the hazards of illness."

During the past several years, we have continually heard philosophy broached that the hospital should be the center of all medical activity. Doctor Parran expresses the same idea: "I am convinced that increasingly, as medical science grows and grows more complex, it can be applied for the people's use with increasing effectiveness through groups of physicians working together. . . ."

I am sure you all realize that there are several methods by which centering of medical activities may be developed at the hospital. However, there is fear of regimentation beyond the War period in a thought expressed by Doctor Parran as follows: "Perhaps the Procurement and Assignment Service could go into reverse and become a placement service."

When one thinks of the many medical school graduates whose residency programs have been disrupted because of their induction into the military service, it is encouraging to know that the Surgeon-General has expressed the hope that the training plans which the President has announced for men on demobilization will include such young doctors. Doctor Parran summarized his recent talk in a vein which I believe demonstrates the value of a medical background as contrasted with that of certain lay bureaucrats when he says: "If any of the pending proposals are unfounded, the professions concerned should formulate better ones. It is necessary that we should be for something better than we have had in the past. We have the knowledge, we need only determination and a will to find acceptable ways of utilizing it fully for all."

I personally believe that it is a sad commentary that a stronger relationship has not existed between the United States Public Health Service and the private physician of the United States. We have in Washington, in this service, men who have attended the same medical schools that we have. Certain of their views may differ from private medicine, but at least we have a common background and through the Public Health Service, from time to time, I am sure we could avail ourselves of the governmental ear to further and direct programs which we feel are beneficial to American health.

AMERICAN MEDICAL ASSOCIATION: ITS ACTIVITIES AND MEDICAL ECONOMICS

Now, let us look at the American Medical Association and its interest in this problem of medical

economics over the past fifteen years. It would be impossible, in the short time allotted to this part of our program this afternoon, to review in detail all the information found in the minutes of the House of Delegates and other publications of the American Medical Association. But I shall attempt, nevertheless, to sketch briefly some of the points which occurred from year to year.

As early as 1928 President Jackson at Minneapolis recommended a council of medical economics. In Portland, Oregon, July 1929, President-Elect Harris discussed the cost of medical care. We find as early as August, 1929, in the *Canadian Medical Association Journal,* a recommendation by Mr. McCullough that a state system of health sickness insurance, including an improved public health service, is desirable.

At the meeting held at Detroit, Michigan, in 1930, President M. L. Harris brought the attention of the delegates to the fact that during the year the Public Medical Service Association of England has been formed for the purpose of establishing universal medical service. Later on in his report he enunciated the fundamental principles proposed by the chairman of the Committee on the Costs of Medical Care, which were unanimously adopted by the General Committee with slight verbal changes: (1) The personal relation between physician and patient must be preserved in any effective system of medical service. (2) The concept of medical service of the community should include a systematic and intensive use of preventive measures in private practice and effective support of preventive measures in public health work. (3) The medical service of the community should include the necessary facilities for adequate diagnosis and treatment.

At the Detroit meeting, Dr. J. B. Harris of California introduced a resolution requesting the consideration of the House in forming a council on medical economics. The purpose of this council to be (1) to investigate conditions of medical economics and to suggest means and methods by which the same may be improved; (2) to endeavor to further the realization of such suggestions as may be approved by the House of Delegates. Both resolutions were referred to a Reference Committee.

It is also interesting to note that in June of 1930 *The Journal of the American Medical Association* carried a report that sick-benefit insurance had been adopted in France.

In July of 1930 the Reference Committee on reports of officers endorsed the work of the Committee on Costs of Medical Care and unanimously approved the principle involved in the recommendation of the California Medical Association in the suggestion for the Bureau of Medical Economics.

In June, 1931, at Philadelphia, President-Elect E. Starr Judd reports that the Bureau of Medical Economics is just being organized and ultimately will have all available information regarding the cost of medical care.

COMMITTEE ON COSTS OF MEDICAL CARE

In December of 1932, an editorial in *The Journal of the American Medical Association* carries a reference to the report of the Committee on the Costs of Medical Care. Significant in this report is the recommendation of the minority group of the Committee: "The minority recommends that the corporate practice of medicine financed through intermediary agencies be vigorously and persistently opposed as being economically wasteful, inimical to a continued and sustained high quality of medical care or unfair exploitation of the medical profession." It is very evident from this abstract that there was no unanimity of thinking regarding this epoch-making report. Reading the report of this Committee on the Costs of Medical Care which appeared in *The Journal of the American Medical Association,* December 3, 1932, page 1954, in the light of our 1943 experience, allows one to appreciate the evolutionary processes which have gone on during the past eleven years.

In July of 1933, a committee on medical economics in its report recommends that the investigation of group hospitalization be continued and that the results of the study be published.

In May of 1934, prior to the meeting of that year, the Bureau of Medical Economics indicated that considerable stress is laid on the tendency of insurance to increase lay control of medical service and to show that this is a universal policy of the insurance administrators and of advocates of insurance in this country; and they also report that there is no definite connection for or against insurance further than to make it clear that existing systems of insurance have failed to solve the problem of medical care.

In June, 1934, at the Cleveland session, a special committee reported, among other things, that it is a well-known fact that voluntary insurance has always been the forerunner of compulsory insurance, and even the most ardent advocates of voluntary insurance admit that fact.

In a special session of the House of Delegates, Febluary, 1935, the attitude of the National Association toward voluntary insurance and toward compulsory insurance was reaffirmed.

CALIFORNIA AND SICKNESS INSURANCE

By May of 1935 there were five columns of *The Journal of the American Medical Association* given over to an article by the editor, entitled "California and Sickness Insurance." It is evident in this article that at the time much thinking was going on regarding health insurance and that the American Medical Association was not in accord with the actions of the Council of the California Medical Association.

In 1937, in June, at the Atlantic City session, a resolution was introduced by Dr. Samuel J. Kopetsky of New York, outlining principles, proposals, and recommendations regarding the development of a national health program. The comparison of certain principles and proposals in this resolution to the present Wagner bill are of interest in retrospect. The same year, Doctor Vohs of Missouri introduced a resolution recommending the establishment of a council on medical ethics and economics, stating that compulsory health insurance

was under consideration by the Federal Government and that he felt much education was needed on the part of the physician. We find that the same session introduced a resolution by Doctor Stone of Ohio on the matter of group hospitalization raising again the question of what should be excluded from such programs and reaffirms the problem as to the definition of hospital service and medical service.

At the Atlantic City session in 1937 a Committee on Legislative Activities pointed out that the recent decision of the Supreme Court, which validated most of the Social Security Act, would open up an avenue for new legislation which could involve the profession of medicine. The Committee felt that the attitude of the medical men throughout the United States would determine such a step. Here we have, just six years later, the introduction of the Wagner bill as an amendment to the Social Security Act, including medical and hospital service.

In the reports of officers in April of 1939, the Bureau of Medical Economics devoted thirteen columns in the Association's journal to a discussion of medical service, hospital service, relations between doctors and hospitals, and related subjects, which indicated great activity on the part of the Bureau during that year.

In June, 1941, a resolution was presented by Dr. Harry Wilson of California, requesting the appointment of a committee to confer with the American Hospital Association and the Catholic Hospital Association. The Reference Committee on Legislation and Public Relations stated that the extra work thrown on the administrative offices of the organization by court procedures and by the medical preparedness program, has made it wellnigh impossible to make a careful study and report covering the subject matter involved in Dr. Harry Wilson's resolution.

The report of the Bureau of Medical Economics on April 15, 1942, stated the following: "No valid reason has been advanced to show that medical service organizations and group hospital plans cannot function separately as parallel services in communities that are sufficiently interested to support such efforts."

SUMMARY REGARDING AMERICAN MEDICAL ASSOCIATION OPINION

It is evident, in the review of fifteen years' minutes of the House of Delegates of the American Medical Association: (1) That there is no unanimity of thinking among physicians regarding medical and hospital coverage either on a governmental basis or on a private basis. This leads one to wonder whether the actions of the House of Delegates and the Board of Trustees of this Association reflect medical thinking in this country. (2) That there has been constant effort year after year, as evidenced by the introduction of resolutions, to try to bring about the culmination of efforts to establish ways and means of bringing health care to that segment of the population who have difficulty in purchasing it. (3) That studies and recommendations of the Committee on Costs of Medical Care remain, to a great extent, historical data. (4) That there is a lack of rapport between American medicine and American hospitalization. It seems unbelievable that private medical and hospital programs can succeed in meeting the problem and either retain their voluntary status without a better understanding and greater teamwork.

COMMENTS ON AMERICAN MEDICAL ASSOCIATION POLICIES

One is led to realize that much, too much, of the activities of the American Medical Association are attempted to be carried out by the voluntary efforts of the House of Delegates year after year. The changing of such delegates and the lack of continuity and contact throughout the years have failed to accomplish continued progressive and straight-line thinking.

When one realizes that the budget of the American Medical Association, as of April 24, 1943, is listed at $1,644,820.96, one cannot but wonder why it has been necessary to maintain to such an extent the *status quo* attitude. Surely, with a budget of this size, more progress might have been expected each year, during the past fifteen years, which would, in the aggregate, build up an answer to the inroads of government. Unfortunately, our public relations program, or lack of program, throughout the country has resulted in adverse criticism of the physician. American medicine needs now, and has needed for years, active positive leadership rather than passive negative leadership.

While we may not have a concrete proposal to meet the suggestions of the Wagner bill on hand, it rests within our province to develop such a program with the active participating support of America's hundred and fifty thousand physicians. The Bureau of Medical Economics, composed of twelve full-time employees on June 1, 1940, has dwindled to five today; at a time when their efforts are needed more than ever before. A reëstablishment of this Bureau and an increase in its personnel should be accomplished by the central office.

The public should know that the American Medical Association, as an organized national body, has contributed immeasurably to the public health and welfare. Its Council on Medical Education and Hospitals has left its imprint on American medicine. Its Council on Pharmacy and Chemistry has been the watchdog and guardian of American pharmaceuticals and the constant advisor to the physician on new medicinal products. Its underwriting program of the archives of the various specialties has given a medium for the dissemination of sound medical knowledge. Its annual scientific exhibits have brought together material of immense value to the physician. Its Bureau of Medical Economics has contributed much to our knowledge during its short existence. Its weekly journal has carried to America's physicians, even in the smallest hamlets, reports and discussions on medical problems which have allowed the American citizens in the smallest communities to benefit by medical experiences in other parts of the country.

PROS AND CONS ON SYSTEMS OF MEDICAL PRACTICE

There are certain thoughts in which I believe both the antagonist and protagonist of any system of medicine will agree:

1. There is a segment of the population which does not know how to secure the medical care that is available to it.

2. There is a vast difference between medical needs and medical demands.

3. For employed individuals earning $3,000 a year or less, some type of prepayment health plan whereby the cost of medical care may be spread is desirable.

4. Hospital facilities need much attention. The existing facilities can stand considerable improvement and alterations to meet present needs. Many rural communities need the addition of hospital facility.

5. The constant presence of a medical staff in and around a hospital may have benefits to the patient and to the physician.

6. There is a growing feeling, not only on the part of the public, but also on the part of some of the medical profession, that the American Medical Association must take more positive action on a national basis than it has in practical methods of distributing medical care more widely.

7. There is a lack of confidence on the part of the physician in a type of Government-controlled medicine.

8. There is lacking satisfactory coöperation between hospitals and physicians on a national level.

9. There is an alleged lack of confidence on the part of the public in organized medicine.

10. There is a real lack of public education in medical practice as it exists.

11. The American public in general still desires free choice of doctor and free choice of hospital when ill.

12. Much greater emphasis should be placed upon the correction of basic conditions which are closely related to ill health. Food, housing, transportation, and employment, if properly planned for in the postwar world, may reduce medical needs considerably.

ON POSTWAR INVENTORIES CONCERNING MEDICAL PRACTICE

I believe that, being faced with postwar health problems, it behooves the medical profession to take inventory of the above thoughts and attempt to determine the truthfulness and the extent to which the above beliefs exist. I believe that we, as physicians, must carry on not only in the postwar world, but during the remaining years of the war, a better public education program which will bring home to the public the tremendous job the medical profession has done. We must get across to them that we have evidence to believe that the American system of medicine is the finest that exists in any part of the world; that we realize, as the physicians of California have demonstrated, the need for a prepaid program for certain segments of the population. The public should be made aware of the fact that the administration, stimulation and continuation of our present system of American medicine, will only go on if those men who are most fitted to insure its existence—namely, the physicians who have brought it to this level—continue to direct its destinies.

From the years 1932 to 1942 in San Francisco alone, there were 5,449,699 out-patient visits to the out-patient departments of this city and no one has written a book about it. From 1932 to 1942 there were hospitalized in our city and county hospital 158,307 patients for 4,119,755 days. The above figures demonstrate service rendered by the private physicians of this community on a voluntary basis without remuneration, and no one has written a book about it. There are today nearly 13 million people covered with group hospital service, and no one has written a book about it. Nearly one-third of our physicians have left their homes and private practices to enter the military service, and the remaining two-thirds of the private practitioners in this country, men in most instances who, because of the military selection, are in the older groups, are now carrying the entire load of medical practice. These men have given up their peacetime privileges and pleasures—and no one has written a book about it. During the past year we have had several large disasters; the one receiving the greatest publicity being that of the Coconut Grove fire in Boston, where 491 people lost their lives and a great many more were injured. Within a two-hour period, 114 were taken to one hospital alone. In this institution, as in many others, the physician, who has been depicted as a medical Shylock, gave his services unstintingly for the unfortunate victims, and in one institution in Boston no fees were charged for any of the hospital service rendered to the disaster victims, and no one has written a book about it. The American medical profession, both in its horse and buggy days and in its present form, has contributed endless hours without remuneration in the care of unfortunates, both in their offices and in hospital clinics. They have also spent endless hours and great sums of their own private money for research which has frequently netted them nothing but discouragement; yet, we know this must go on—but no one has written a book about it. I personally believe that the greatest job facing the American medical profession at the present time is a public relations program based on factual data and free from emotionalism. The American public must know the story if they wish to preserve that which we think is valuable. Of the 135 million people in the United States, only about 150,000 are physicians. We cannot, by any stretch of the imagination, represent a monopoly. The American people must decide what they wish and we shall be compelled to do their bidding; but our responsibility rests in educating that American public as to what they have and what they may give up under a new system.

DECISIONS EVERY PHYSICIAN SHOULD MAKE

Every physician should decide which of the following systems he wants:

1. A completely federalized system for all Americans with part of the puppet strings pulled by the United States Public Health Service and part by a lay Social Security Board.

2. A system owned, financed and operated by industry which may rise and fall with Dow-Jones averages.

3. A system directed and guided by physicians, including county or federal care for the indigent, applying the prepaid principle to the lower brackets and allowing the doctor to charge a private fee to others.

4. A system directed and guided by commercial insurance companies, or

5. A system that remains *status quo* and sings its theme song of "stand-patism."

I should like to make the following recommendations, to which I claim no originality:

RECOMMENDATIONS: IN RELATION TO NATIONAL NEEDS

1. A full-time resident representative with diplomatic experience in Washington.

2. Whole-hearted coöperation with the United States Public Health Service.

3. Whole-hearted coöperation of the American Hospital Association and the American Medical Association.

4. A definite stand by the American Medical Association for prepaid health insurance on a voluntary basis.

5. Establishment of a Medical Service Plan Commission within the American Medical Association to collect and pool the experience of the constituent state societies regarding prepaid medical service.

6. Employment of more full-time personnel for study of voluntary health insurance with reëstablishment and expansion of the Bureau of Medical Economics.

7. A public relations program which will win back for the physicians as a whole greater respect from the public and which will change the opinion toward the American Medical Association from that of a monopolistic body to one of guardianship and trusteeship of America's most sacred need—medical care.

8. A review of the studies of the Committee on the Costs of Medical Care in the light of the Wagner bill.

9. Expenditure of as much time in studying methods of distribution of medical care as we have spent in the improvement of medical care.

RECOMMENDATIONS: IN RELATION TO CALIFORNIA'S NEEDS

1. Formation of a state-wide nonprofit hospital service plan in accordance with the recommendations of the Mannix survey.

2. Stimulation of greater interest on the part of the physician in California Physicians' Service.

3. Amalgamation of administrative and enrollment programs for the state-wide hospital and medical service plans.

4. Continuation of the coöperation which now exists between the California Medical Association and the California State Department of Public Health.

5. Coöperation of physicians and hospitals with the Procurement and Assignment Service of the War Manpower Commission and other governmental agencies in the prosecution of the war.

6. Continuation of interest and study in the methods of distributing medical care in California.

Lane Hospital, Clay and Webster Streets.

MEDICAL PRACTICE: ITS EVOLUTION*

MORRIS FISHBEIN, M. D.
Chicago, Illinois

DURING the three years following World War I, more people died from famine and preventable disease than lost their lives in the War itself. Already a half-dozen uncoördinated agencies of the Federal Government are dealing with the various phases of the problems related to health that are likely to become prominent in the postwar period.

The building of hospitals, the redistribution of physicians, the prevention of disease, the promotion of health, the development of health centers, the determination of nutritional deficiencies, the rehabilitation of medical material and equipment, and the distribution of trained scientific personnel, are among the activities related to health which demand study and for which there must be planning. Even now a half-dozen governmental agencies are actually competing with one another for the available medical personnel and the available medical supplies. In the postwar period such competition, under uncontrolled conditions, might well be ruinous.

If there is one need outstanding at this time it is the establishment of an overall governmental agency to which would come the demands for medical personnel, medical supplies, hospitals and hospital equipment or other medical needs. From such an agency allocation or recommendations might be made on the basis of exact knowledge or inventory such as is now kept by the Procurement and Assignment Service for Physicians as to the availability of physicians, and by the War Production Board as to the availability of materials. Such an agency would equally be in a position to advise the President, the Congress, or the individual bureaus of the Federal Government as to medical necessities and the possibilities of meeting the existing needs. From the very nature of its work such an agency would include in its member-

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* From the office of the editor of *The Journal of the American Medical Association* and *Hygiea*.
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